

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005020	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/11/2013
NAME OF PROVIDER OR SUPPLIER PARKVIEW REGIONAL MEDICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 11109 PARKVIEW PLAZA DRIVE FORT WAYNE, IN 46805		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>The visit was for investigation of a State hospital complaint.</p> <p>Complaint Number: IN 00119118 Unsubstantiated; lack of sufficient evidence.</p> <p>Survey Date: 3-11-13</p> <p>Facility Number: 005020</p> <p>Surveyor: Brian Montgomery, RN Public Health Nurse Surveyor</p> <p>Parkview Regional Medical Center is in compliance with 410 IAC 15-1.5-10, Utilization review and discharge planning services, Hospital Licensure Rules.</p> <p>QA: cloughlin 03/19/13</p>	S 000		

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

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If continuation sheet 1 of 1